KanCare Overview for Consumers
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Thank you Gary. I appreciate all of you being here tonight. My name is Shawn Sullivan. I'm with the Department on Aging and Disability Services and what I want to do for you is give you a little bit of an overview of KanCare and then when I'm done, we'll have some of our staff that will get up and give you specific scenarios of how this may impact you depending on the type of services that you or your family member or loved one may receive. So with that let me kind of get into this.

So, Medicaid serves 383,000 Kansans. It's a significant program for the number of people we serve. It's a very important program on the type of services that we offer and the care and services that are provided. It is a $3.8, excuse me, $3 billion program. It's a very significant cost, again, a very important cost to the state.

When the Governor took office last year in 2011, the Medicaid program and 383,000 that we serve, $3 billion program was operating with approximately $200 million deficit. We transferred that money from the Department of Transportation with that year's budget in order to give us time to give a longer term look at the program and determine what some alternatives were and how we could change the services we provide for the better, better outcomes and also look at what other states are doing.

You'll see again, what I said already, the second bullet point up on the screen. More and more people every year are enrolling in Medicaid. There's about a five percent increase in number of people we serve every year to where we are now at 383,000. And then there's also a seven and a half growth in the cost per year over the last 10 or 12 years. So, the cost is a primary reason we started taking a look at this and what we could change but the second reason, probably more importantly is the outcomes and the measurements that we looked at and just how well we do at serving through Medicaid.

So, what we found was that we had a lot of opportunities for improvement with how well we serve and how well we keep people and older adults out of nursing homes, how well we do with coordinating care for persons with disabilities, how well we do with providing incentives for healthy lifestyles and health promotion, wellness benefits to the pregnant moms and kids that we provide benefits for. So, while the program had not been paying for, or has been paying for immediate medical needs, we wouldn't necessarily say it's paying for or covering overall health issues of the persons served through Medicaid.

The three groups that we serve through Medicaid, those 383,000 are up on the screen. The first group are children, families and pregnant women. That actually has the largest percentage of those we serve on the caseload, but has the smallest percentage of the cost. And when we went around and talked to Kansans last year and consumers, what we found was this group tends to go in and out of Medicaid frequently and may lose coverage and then be approved again and go off and on.

The second group are older adults. And there's around 35-36,000 we serve in this group. And what we've found is an opportunity for improvement, was that we have a higher than average, much higher than average percentage of older adults living in nursing homes…the counties in the state have an average higher than the national average which is 3.8 percent.

And then the third area that you'll see up on the screen, 57,000 are persons with disabilities. So, as Gary mentioned our agency serve several what are called Home and Community Based Services programs or waivers, from those that are physically disabled waiver to the intellectual and developmentally disabled

waiver, technology assistance, autism, and seven in total. And what we found after talking to Kansans last year about the persons with disabilities group is really that we have a very fragmented, what we call fragmented type system and I'll cover more of what that means here in a second.

So, what we did when we knew we needed to change the system and we couldn't keep digging the hole that we were in, was to go around Kansas and we went and talked to thousands of Kansans and consumers, families and providers and advocates and associations, and asked them "what do you like now, what would you like to change, how's it serving you well, how's it not?" and we also looked at what other states are doing and what direction the federal government is going.

So, with that there were four major themes that we heard when we went around the state. And you'll see those up on the screen on the left side. And they are to improve or to have integrated, whole-person care, the second was to create a path or improve the path to independence. The third was the need for alternative access models. And the fourth is to do a better job of keeping people at home or enhancing community based services.

So, those correspond with the state of Kansas goals we developed on the right side of the screen to improve health outcomes and care, bend the cost curve of the program and spending down over the next several years and then also not have as part of this eligibility cuts through making this harder to be on Medicaid or restricting provider access or choice or third, cutting reimbursement rates to providers. And then we also wanted to address the key stakeholder themes that we heard as we went out and talked to people.

So, what we found when we talked to other states and did our research were, and this is something that we've done in Kansas before, kind of the easy three things that changes that can be made. The first is to cut provider payments. This is to nursing homes, to doctors, hospitals, case managers, disability providers, to cut their payment to them to provide services to you or your family members by to two, five, 10, 15 percent. Some states are even in the double digits with what they've done. That is really the easiest way to save money on Medicaid. But that's something that we felt was not a direction we should go, not a direction that was wise in order to continue to have providers, community providers that are willing to provide care and services.

And the second was to, as you see on the screen, reduce the number of members that we have on Medicaid and make it harder to get on the Medicaid program or even to increase copays or some of those things.

And the third thing that we decided not to do, that we took off the table was reducing the scope or level of services. So, instead of doing those three things what we've offered is a program of what we'll be calling KanCare next year in 2013 called KanCare, a Medicaid program called KanCare.

So, the four major changes that will be starting in 2013 through KanCare are up on the screen. The first is moving towards a concept called person-centered care coordination. The second is moving towards where we have clearer responsibility. The third is improved outcomes in care and services. And the fourth is less complex funding reimbursement.

So, let me spend some time on this first concept of person-centered care coordination. So, as we have taken things off the table, and we said we're not cutting the rates to providers, we're not cutting services and we're not restricting access or limiting provider choice, then the question, very good

question is, how are you going to save money? If this is a spending concern, how are you going to save money if you can't do those three things? And our answer really is, by doing a better job. And we think the way we do a better job is through care coordination.

So, number one, there will be some new services that will be offered kind of at the floor, at the minimum the services that we offer on Dec. 31 of this year through the Medicaid system we have now will be at least that on Jan. 1, when KanCare starts. But we'll also have several new services that will start that we think will help provide health promotion and prevention and types of things that we need to save money, have better outcomes, provide better care. So, you'll see some of those listed up on the screen. The first is heart and lung transplants for adults, weight loss surgery if needed, and the third that will touch a lot of people is value-added services.

So, these are things that we ask the companies that were bidding on this and that we provided contracts for which are Amerigroup, Sunflower Health Plan and United Health Care. We asked them through this process, what are some things that you can do to provide for health promotion, for preventative type care, additional benefits that we do not offer today that you can offer when we start KanCare, that will be of value to those we serve.

So, they each came up with a very unique list of what they're going to offer. And there were some commonalities or some services that were the same between the three. Those were things like preventative dental services between the three plans, that is not offered now as of today in Medicaid. There were wellness memberships some of the plans offered or will offer, wellness memberships to local gyms or health club. Some of the health plans or three companies will offer smoking cessation plans and just good preventative-type measures.

There will be some services that will be offered by one or two of the plans but not the third. And that is to promote competition between the three and have differences between the three plans. But there are a lot of great services that will be added in January of next year when KanCare starts, that are not offered today that we think will enhance what is being received through Medicaid or in 2013 through KanCare.

So, the third thing that you see up on the screen is the health homes. And what health homes are, it's not a place, it's not a building, it's not a care center, it's not a thing like that. This is a concept that means we want to provide a care coordinator for every person on Medicaid. So, I think we can all think of personal examples, maybe it's your parent, a brother or sister, a grandparent, aunt, uncle, a child, someone that you help that goes to their primary care, that goes to their physician here in Leavenworth, Lansing, wherever it may be. And then they're referred to a diabetes specialist, they're referred to an orthopedic doctor, they're referred to someone else. Then you go see that person and then if you know someone that maybe receiving services from the family guidance center here in Leavenworth, you may be sent there. And then, so often, I have a couple of family members that I can think of immediately that have seen six, seven, eight different people or providers, physicians, doctors, hospitals, there may be a nursing home too or case managers. What we see as the problem is there's not one person or organization that is helping coordinate the care or coordinate the services for all of those six or seven different people or doctors, long term supports providers. What we have is all these different systems. You go to the window, then you go here, you go see this person, you're referred on, but usually they're not all talking to each other.

I give the example often of a family member that I have that passed away two years ago in another state. He was on that state's Medicaid program. That Medicaid program was similar to our Medicaid program here in Kansas. And he was seeing a mental health counselor similar to the guidance center here in Leavenworth. He of course was seeing his physician, his diabetes specialist, liver specialist. He was seeing seven different providers, physicians, doctors and so forth. And there wasn't any entity. He even had a case manager similar to what we have here in Kansas that was helping set him up with attending care, bathing and housekeeping. But he did not have any organization or any person that was helping him know "I need to go to the doctor tomorrow; I need to be taking these medications." He didn't have anyone helping him know what the diabetes doctor was prescribing with something that was counteracting what the mental health counselor was telling him. And as a result, he bounced in and out of, between his home and the hospital, and between his home and the emergency room 29 times in the last year and half of his life. So, that's a very overgeneralized type example. It doesn't happen very often, but I can think of my grandmother, I can think of aunts and uncles, I can think of people I've served over the years in various parts here in Kansas, that have had similar type situations where we haven't done a very good job with the system we have now of making sure all the needs of a person are taken care of.

So, some of you may be served by a Home and Community Based Services or HCBS case manager through your developmentally disabled organization or your center for independent living or an area agency on aging or whatever it may be. But even those systems for the most part are there to set up attendant care and housekeeping. They're not there to make sure your doctor knows what a mental health counselor is doing or they're not there to make sure that your provider or your attendant care worker that's helping you every day knows what all the other people are doing and they're not responsible to make sure the symptoms that they should be looking for diabetes or for whatever condition may be there, um, are plugged in.

So, what the main change that we have that will be coming through KanCare, is this care coordinator that every person will have. They'll be responsible to make sure that all these different systems, providers, doctors and attendant care workers are talking to each other and communicating on a very frequent basis. This will both be an in-person type situation and also may be over the phone to make sure that if you're at the hospital and you've gone home to make sure that you're going back to the doctor in so many days, that you're taking your medication, setting up additional doctor visits. This person will be helping provide those services, which we think will be of huge help.

So, I often get asked, "If you're not cutting services, if you're not cutting rates, if you're not cutting providers, how are you saving money with KanCare?" And our answer is through this care coordination. Through people like my uncle that went to the hospital 29 times and the state paid for him to go to the hospital 29 times. It's for him to have a much better life, much better outcomes because he'll be able to stay at home longer and to make sure he's doing what he should be doing and make sure those seven different people are communicating and providing him with whole-person care as we call it.

So, these health homes will be set up to help us achieve that. And our first focus or priority in the first year of KanCare will be any person that we serve that has a mental health need or that has diabetes or both, will be in a health home with a care coordinator by the end of the first year. And then our second priority, uh, is, because this will take time to build capacity and get the providers to do this, change our system. In the second year, so by the end of 2014, anybody that we serve through Medicaid that has a complex condition, chronic conditions, complex needs will be within one of these health homes.

Um, the fourth thing that you see up on the screen that we think will help with this care coordination is you will have help understanding choices about your care. We're in the process of setting up aging and disabilities resource centers. These will primarily be for those that are older adults or frail elderly on the HCBS waiver, for those that are on the physically disabled HCBS system, or for those that are on the traumatic brain Home and Community Based Services system.

So, what these aging and disabilities resource centers are, or ADRCs for short, they will perform what's called eligibility for Medicaid, so they will tell people that are already on a system or people coming on new, that yes, you're eligible. And then they will help that person or help that family member decide and help them work through these are the three plans—Amerigroup, Sunflower Health Plan and United Health Care. These are the differences between the three plans, these are the different services that are offered, these are the physicians that are in each plan or your providers. And then they will help you work through that and then, um, help you determine which plan is best for you.

And then lastly, we also have in order to achieve care coordination safeguards for provider payments and quality.

So, the second major change that I covered was that we have added clear responsibility. As we try to have, provide better care and services and better outcomes and fewer hospital visits and fewer nursing homes, we need data to be able to achieve that, so, as you see up on the screen, we've required that each of the three companies have a health information system that will have to report data to us, report data to the federal government. We will have a very transparent system as we move forward. We are taking away or withholding three percent of their contract money we pay them until the end of the year, until they demonstrate how well they do on those six things. And then, we will then as we start making changes and start measuring the outcomes and the data, in 2014 and 2015, the second and third year of this program, we will withhold five percent of the contract amount on 15 different measures, pay for performance measures. And those 15, five of them are physical, medical measures, like diabetes related or hospital related type things. For the pregnant moms and kids population group, there are measures such as the percentage of well child visits within the first 15 months of birth. There's there's those types of things. There are five measures that are related to behavioral and mental health. And then there are five measures that are related to long term care and supports, HCBS systems and those that we work on there.

So, those are our measures where if they achieve those, they'll get their full five percent at the end of the second and third year. And they are how we are incentivizing the things that we think will happen which are on the next screen through improved outcomes. So, this is really one of the main focuses of this system. Instead of paying right now on July 31, what we do is we pay thousands of organizations like doctors and hospital and nursing homes and case managers. We're paying them based on how many people they serve. We are not paying them, for the most part, on how well they are serving their members or persons with disabilities or older adults. So, that's the kind of system we are moving towards with KanCare, is paying based on how well we do, not on the number of people or volume that we are serving.

A few of those things that we will be incentivizing, a few of our expectations are up on the screen. We want to do a much better job of keeping, particularly older adults and persons with disabilities at home, healthy, independent, happy, as long as possible. And we have a number of changes that will be occurring to help us realize that goal.

Number two, we want to have fewer hospital visits, so people like my family member that was in and out 29 times through our doing a better job of of making sure all his seven different doctors and case managers are talking to each other and doing a better job of that will keep him out of the hospital and keep the state from paying for those high cost services through this care coordination.

Third, doing a better job of caring and providing, preventing illnesses, chronic conditions, things like diabetes and COPD, heart conditions, all those types of things that make it very hard sometimes to keep people at home, those that we serve, healthy and independent. So, there are a number of things we'll be looking at, measuring with ongoing illnesses and chronic conditions.

And then the fourth is improving access to health services. So, the care coordinators will be helping quite a bit with access to services. And we have a couple of physicians that we've had that have helped us develop this KanCare program, and they give examples often, including Dr. Moser who is the secretary for the Kansas Department of Health and Environment. He used to operate and have a clinic in way out in Tribune, Kansas, which is about a far away as Leavenworth, Kansas as you can get, in western Kansas. And he talks often about the challenge he had with his patients trying to find specialty providers for his persons he served in Greeley County in Tribune.

So, one of the expectations we have of these care coordinators is as they go to the primary care physician, as they're referred on for other services in order to keep them healthy and to coordinate their care, these care coordinators will help find those services and they will pull from their statewide network and provider networks that we believe will be much more robust and larger than what we have now with our current Medicaid program.

And then the fourth change that I mentioned earlier was less complex funding. Um, again, so right now, July 31, 2012, we pay thousands of organizations, doctors, hospitals based on the number of people they serve. What we're moving towards with KanCare is based on how well we serve those 383,000 Kansans.

So, the plans will be paid to help you get all the services you need. It's very important to us that we're not restricting or cutting the scope or level of services that are offered. And the plans will be rewarded for paying for care that keeps persons, the 383,000 healthy before they get sick. So, that's truly what we are trying to incentivize with KanCare.